CHAPTER 3
SECTION 15.8

PERCUTANEOUS LUMBAR DISCECTOMY (PLD)

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I. PROCEDURE CODE

62287

II. DESCRIPTION

Percutaneous lumbar discectomy (PLD) is one alternative to open surgery for treating herniated lumbar intervertebral discs that fail to respond to conservative therapy. PLD can be performed either manually or with an automated device. In manual PLD using a pituitary type of instrument, nuclear material is removed from within the disc annulus by cutting forceps. Automated Percutaneous Lumbar Discectomy (APLD) is a conservative surgical procedure that removes ruptured or herniated discs in the lumbar spine. APLD is accomplished by inserting a cannula/probe into the disc space with fluoroscopic guidance. Once in place, cutting, irrigation, and aspiration of the nucleus material is performed until no further material can be removed. PLD is usually performed under local anesthesia and can be performed on an outpatient basis.

III. POLICY

A. Percutaneous lumbar discectomy is considered a covered benefit in cases of selected patients who have met all the following criteria:

1. Must be between the ages of 18-50 years old;

2. Must have a physical and diagnostic image confirming the presence of an uncomplicated, contained disc herniation within the annulus;

3. Major complaint of acute unilateral leg pain (i.e., persistent radicular pain) or a major complaint of acute and intractable discogenic back pain consistent with a herniated lumbar disc contained within the annulus;

4. Neurologic signs or symptom(s) (e.g., sensory abnormalities, reflex alternations, positive straight-leg raising test, weakness) that are consistent with a herniation contained within the annulus of the disc; and

5. Radiographic evidence revealing the presence of an annular disruption or herniation that is located in lumbar spine (L1-L2 to L5-S1) and consistent with the signs and symptoms.

6. Attempts to relieve pain and other signs and symptoms under the supervision of qualified medical personnel through such conservative therapy as bedrest, physical therapy, analgesics, and muscle relaxants, have failed.

B. The device is approved by the Food and Drug Administration (FDA) for commercial marketing for the specific application and must be medically necessary for the treatment of the condition for which the device is intended to be used.

IV. POLICY CONSIDERATIONS

A. Percutaneous lumbar discectomy performed for herniated lumbar intervertebral disc during the first month of low back pain symptoms (with or without sciatica), unless progressive neurologic impairment, including cauda equina syndrome, occurs, is not covered.

B. If sciatica is present and symptoms persist longer than one (1) month without improvement, percutaneous lumbar discectomy is a reasonable option to treat a patient's herniated lumbar intervertebral disc.

V. EXCLUSIONS

Percutaneous lumbar discectomy is NOT eligible for reimbursement for patients who demonstrate any of the following:

A. History of previous chemonucleolysis (failed back surgery syndrome) or surgical treatment of the disc presently suspected to harbor a symptomatic herniation;

B. Progressive neurologic dysfunction.

C. Evidence of a sequestered disc or free fragment of disc; or

D. Evidence of a vertebral disease such as degenerative spinal stenosis or spondylolisthesis.

VI. EFFECTIVE DATE

As of February 1, 1990, the Percutaneous Lumbar Discectomy procedure became a covered benefit for individuals with a single, uncomplicated herniated lumber disc. However, the implementation of this policy modification will cover a single or multilevel herniated disc.

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